benefits: First, the filling of the LV cavity during diastole will maintain RV geometry. (This was indicted in the article by the displacement of the septum with LV filling, Figure 5). This more physiologic shape in diastole may affect the compliance of the right ventricle with subsequent beneficial effects on wall tension and subendocardial perfusion. Again, the use of the diastolic pressure-volume curve may identify this. Second, LV ejection will add pulsatility to the systemic arterial supply, which may allow greater perfusion at marginal pressure gradients.

Mark H. Danton, MD
Cardiac Surgical Department
Royal Group of Hospitals
Belfast, Northern Ireland BT12 6BA,
United Kingdom

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Reply to the Editor:

My colleagues and I appreciate the questions raised by Danton in his letter to the Editor. The relationship between maximum right ventricular (RV) function and systemic pressure was suggested in 1955 by Peter Salisbury.[1] On the basis of this early study, we[2] demonstrated that, at the onset of RV failure, the RV free wall becomes ischemic, and this ischemia and failure can be reversed by raising systemic pressure. Although we believed that the entire matter was simply an issue of RV perfusion, additional studies from our laboratory began to cast doubt on this hypothesis. Page and associates,[3] using a model in which the right coronary circulation perfuses only the RV free wall, demonstrated that the maximal pressure developed by the right ventricle is determined primarily by maximal developed left ventricular (LV) pressure, and not by right coronary perfusion pressure. The issue of RV free wall versus left heart contribution was further explored by Damiano and colleagues[4] in a model in which the RV free wall was electrophysiologically isolated from the rest of the heart. They demonstrated two distinct contributions to global RV function: one derived from RV free wall contraction and one derived from contraction of the left side of the heart. On the basis of these studies, we undertook the study recently published by Klima and coworkers[5] to investigate further the nature of left heart contribution to RV function.

Putting together the findings of our recent study with the prior work has led us to conclude that approximately half of RV function is derived from the contribution of the free wall, which is dependent on perfusion pressure, combined with a significant contribution from the left side of the heart, that is, via the interventricular septum. Furthermore, in our study, even when no LV preload was introduced into the left ventricle, the ventricle still developed pressure because of blood returning to the left side of the heart through the thebesian vessels; in our preparation, peak developed LV pressure closely correlated with aortic pressure, irrespective of left heart output. Although we do not deny the role of RV free wall ischemia in the pathogenesis of RV failure, we do maintain that the process is complex with multiple determinants.

Irrespective of mechanism, our study supports the physiologic principle that developed LV pressure, and hence systemic pressure, must be maintained when treating patients with RV failure.

Gus J. Vlahakes, MD
Massachusetts General Hospital
55 Fruit St—BUL 119
Boston, MA 02114-2696

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Thymolipomas with myasthenia gravis in Japan

To the Editor:

With great interest we read the article, "Thymolipoma in Association With Myasthenia Gravis," by Zambudio and colleagues.[1] They reviewed 18 case reports about thymolipoma with myasthenia gravis, including 3 Japanese cases.

We also reviewed 14 case reports about thymolipoma with myasthenia gravis in 1993.[2] To our knowledge, there are 9 cases in Japan, including our new case (Table 1).[2-4] The patients comprised 2 men and 7 women, with a mean age of 50 ± 14 years (29-76 years). The mean thymolipoma weight was 385 ± 355 g (55-850 g). Thymolipomas with myasthenia gravis appear in older patients and are smaller than thymolipomas without myasthenia gravis (mean age 34 ± 18 years, mean weight 640 ± 650 g) according our previous review.[5]

As Zambudio and colleagues discussed in their comment, we think the best current surgical treatment for thymolipoma with myasthenia gravis is extended thymectomy.[2] We also think that extended thymectomy is the preferable surgical treatment for thymolipoma even without myasthenia gravis, since patients with thymolipoma may have a high titer of serum antiacetylcholine receptor antibodies.[5]

We thank Zambudio and colleagues for calling attention to this subject.

Mitsuhiro Yamamura, MD, FICA
Takashi Miyamoto, MD, FICA
Hideki Yao, MD
Department of Thoracic &
Cardiovascular Surgery
Hyogo College of Medicine
1-1 Mukogawa-cho, Nishinomiya-city
Hyogo 663-8501, Japan

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TABLE 1. Reviews of thymolipoma with myasthenia gravis in Japan

Author	Age (y), sex	Weight (g)	Osserman
Tsuchiya (1965)	45, F	—	—
Miyairi and Iizuka (1984)	48, F	850	IV
Yamanaka (1987)	55, F	186	IIb
Hongo (1987)	76, F	156	IIa
Hirai (1988)	40, F	—	IIb
Narita and Toyama (1991)	48, F	680	—
Yamamura (1991)	65, F	—	I
Takamori and Hayashi (1997)	29, F	55	—
Okumura (2001)	41, M	—	IIb

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Reply to the Editor:

We read with great interest the letter to the Editor from Yamamura, Miyamoto, and Yao in response to our article, in which reference is made to the Japanese experience in this matter. Our interest in this rare association arose when in our daily routine we encountered 3 patients with this condition and were uncertain of the best approach and follow-up. Accordingly, we analyzed the bibliography to which we had access and observed several difficulties, due not only to the diverse nature of the journals, some of which are difficult to locate, but also to the number of different languages in which they are published. Today, the only information that exists for physicians with scientific curiosity is the material to which they have access, that is, that which is available in their own language and particularly publications in English, which now is the scientific language of reference. It must be remembered that the journals with the greatest impact, circulation, and scientific rigour are those that appear in English. Information in non–English-language journals is usually relegated to local (nationwide) distribution. This means that the best studies will not be published in these local journals, as they have no impact on the scientific population, and will be sent to more prestigious journals. Moreover, articles that have not been accepted in impact journals often end up in the local literature. This may occasionally lead to the submission of lower-quality studies, and to the scientific committees of these journals demanding less scientific rigour in order to meet a minimum volume of articles.

On this basis, we are convinced that the 18 cases of myasthenia gravis in thymolipoma that we reviewed represent just the tip of the iceberg of cases throughout the world. The problem is that not all cases are documented. Publishing an article requires dedication and bibliographic research, and if it is to be submitted to an English-language journal, many of us need to have it translated into English. All this involves time and nonremunerated dedication, generally at the expense of time spent with the family. We believe it is important to take advantage of the effort made by Yamamura, Miyamoto, and Yao to review all the cases in Japan, because they have almost doubled the number of cases known and available to the scientific community. We are aware of the rigorousness and seriousness of Yamamura's work, both clinical and scientific, and can therefore vouch for the data that his group reports. We all believed that there were more cases of this association in the world and therefore consider that the message of Yamamura, Miyamoto, and Yao should not be limited to saying there are 14 cases more. If their contribution is to be of interest to the scientific community, I would recommend that they include a more complete table to enable us to draw conclusions from the findings. I believe, for example, that the table should include at least the following: author, age, sex, preoperative evolution, thymolipoma weight, postoperative evolution, relapse, and follow-up time. A table of this kind in an impact journal such as *The Journal of Thoracic and Cardiovascular Surgery* would allow such information to reach most of the scientific community engaged in thoracic and cardiovascular surgery and would help all of us with an interest in the subject to broaden our knowledge of this association.

Antonio Rios Zambudio, MD
Juan Torres Lanzas, MD
Maria José Roca Calvo, MD
Department of Surgery and Department of Thoracic Surgery
Virgen de Ia Arrixaca University Hospital
Murcia, Spain
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